

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10142

10150

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>		d. STREET ADDRESS <b>12 West Third Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LEWIS</b>		First <b>HAMILTON</b>	Middle <b>ALEXANDER</b>	Last <b>ALEXANDER</b>	4. DATE OF DEATH <b>September 14, 1958</b>	Month <b>September</b>	Doy <b>14</b>	Year <b>1958</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 20, 1876</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Court Bailiff</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Martin E. Alexander</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Stockman</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>21-10-9629</b>		17. INFORMANT <b>Mrs. Sylvia A. Alexander-Same as Item #2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> DUE TO <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) _____ DUE TO _____ (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>A-S. Parkinsonism</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Oct 14, 1958</i> to <i>Sept 14, 1958</i> , that I last saw the deceased alive on <i>14 Sept 1958</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Charles H. Conley, Jr.</b> <b>Professional Building,</b> <b>Frederick, Maryland</b>								
ACTUAL SIGNATURE <i>Charles H. Conley, Jr.</i>		DATE SIGNED <b>9/15/58</b>						
PHYSICIAN'S NAME (Type) <b>Dr. Charles H. Conley, Jr.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Hope Cemetery</b>		22d. LOCATION (City, town, or county) <b>Woodsboro,</b> (State) <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. <b>SEP 18 1958</b> BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Amelia L. Krause</i>		

DEPARTMENT OF HEDONIC—BALTIMORE, MD.

CERTIFICATE OF DEATH

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**FOR STATE  
HEALTH DEPT.**

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**V.S. A15ME**  
**5M 2/57**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
New Market		1 day		X Rural--Mt. Airy					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				R.F.D. 1					
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle E.	Last ANDERSON	4. DATE OF DEATH	Month SEPT.	Day 26	Year 1958	
5. SEX male		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11-15-1943	9. AGE (In years last birthday) 14 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY in school		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
Student									
13. FATHER'S NAME Stanley Anderson		14. MOTHER'S MAIDEN NAME Zelma L. Dorsey		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.4 DUE TO <i>Errol Thomas</i>			INTERVAL BETWEEN ONSET AND DEATH
no				Mrs. Zelma L. Anderson, Same					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in farm pond							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9 26 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm		20f. (City or town) New Market, Frederick, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B.L.Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-26-1958	
EXAMINER'S NAME (Type) <i>B.L.Thomas</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-29-1958		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		22d. LOCATION (City, town, or county) Carroll Co., Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.				24a. REC'D BY REGISTRAR SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH - MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
OF MARYLAND

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10144

10151

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doubs</b>		d. STREET ADDRESS <b>/</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Odie</b>	Middle <b>M.</b>	Last <b>Baker</b>	4. DATE OF DEATH	Month <b>9</b>	Day <b>29</b>	Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/1886</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Keller</b>		14. MOTHER'S MAIDEN NAME <b>Emma Brown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Vernon S. Baker, Doubs, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</b>		<b>Acute pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>		
(b)		DUE TO <b>Coronary artery disease</b>				<b>2 yrs.</b>		
(c)		<b>Arterio-sclerosis c hypertension</b>				<b>4+ yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Frederick</b>		(State)
21. I certify that I attended the deceased from _____, 19 <b>57</b> , to <b>9/29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/29</b> , 19 <b>58</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles H. Conley Jr.</i>		ADDRESS (Street, city or town, state) <b>Professional Bldg</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10/1/1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ch. of Brethren Cem.</b>		22d. LOCATION (City, town, or county) <b>Harmony, Frederick Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company</b>		ADDRESS <b>Middletown, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10175

## CERTIFICATE OF DEATH

Reg. Dist. No.

10145

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick 35</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 East "A"</b>			d. STREET ADDRESS <b>309 East "A"</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Jane</b>	Last <b>Barger</b>	4. DATE OF DEATH	Month <b>9</b>	Day <b>16</b>	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-1898</b>		9. AGE (In years last birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Henry Rothenhoefer</b>			14. MOTHER'S MAIDEN NAME <b>Martha Ellen Harshman</b>			Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ellen Sponseller, Brunswick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 days.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-9-18</b> to <b>9-16-18</b> , that I last saw the deceased alive on <b>9-16-18</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. E. Pruitt</i>				ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b> DATE SIGNED <b>9-16-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Petersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Felt</i>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

## MAYA LUDIEN STATE DEPARTMENT OF HAITI - GENEVA OFFICE

## CERTIFICATE OF DEATH

NAME	ADDRESS	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH
John Doe	123 Main Street, Anytown, USA	45	Male	1985-05-01	10:00 AM	Cardiac Arrest
This certificate is issued by the Geneva Office of the Maya Ludien State Department of Haiti, to certify the death of John Doe, on May 1, 1985.						
Signed: Dr. Maya Ludien, Physician-in-Charge						
Date: May 1, 1985						

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10152 CERTIFICATE OF DEATH

10146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodsboro</b>	b. COUNTY <b>Frederick</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		d. STREET ADDRESS <b>—</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <b>ELSIE</b>	Middle <b>G.</b>	Last <b>Boone</b>
4. DATE OF DEATH <b>Sept. 19</b>	Month <b>Sept.</b>	Day <b>19</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1872</b>
9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months <b>—</b>	11. IF UNDER 24 HRS. Days <b>—</b>	12. IF UNDER 24 HRS. Hours <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Daniel P. Zimmerman</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Stitely</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mrs. C. W. Miller-Woodsboro-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic C.V.D.</b> DUE TO (c) <b>Diabetes Mellitus</b> 7 days 10 years 7 years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 11, 1945</b> , to <b>Sept. 19, 1958</b> , that I last saw the deceased alive on <b>Sept. 19, 1958</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard O. Thomas Jr.</b>		ADDRESS (Street, city or town, state) <b>228 N. Market St.</b> DATE SIGNED <b>9/19/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. Bernard O. Thomas-Jr. Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9-21-1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MT. HOPE CEMETERY</b>	22d. LOCATION (City, town, or county) <b>Woodsboro - Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 22 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

87.39CM由人足-脚掌尺侧缘第1跖骨基部-足背尺侧缘

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10147

10179

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Graceham</b>		c. LENGTH OF STAY IN lb <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>X Graceham</b>	
f. NAME OF DECEASED (Type or print) <b>Lemuel</b>		g. DATE OF DEATH Month <b>Sept.</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Jacob Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>219-36-2981</b>	17. INFORMANT <b>Mrs. Warren Grushon</b>
		Address <b>Graceham, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO myocardial ischemia (c)		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Direct inguinal hernia, right</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 31, 1958</b> , to <b>Sept. 6, 1958</b> , that I last saw the deceased alive on <b>Sept. 6, 1958</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>Franklin BARELY</b>	
ACTUAL SIGNATURE <b>M. FRANKLIN BARELY</b>		PHYSICIAN'S NAME (Type) <b>M. FRANKLIN BARELY</b>	
22a. BURIAL, CREMATION, (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-9-58</b>	22c. NAME OF CEMETERY OR CREMATORIALy <b>United Brethren Cem.</b>	22d. LOCATION (City, town, or county) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 10 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Estelle S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

10130

DECEASED

DECEASED

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE	DEATH NUMBER
EDWARD J. KELLY	50	Male	APRIL 25, 1951	10:00 A.M.	Heart Disease	10130-5104
MARY E. KELLY	50	Female				
EDWARD J. KELLY	50	Male				

Edward - with  
Mary Kelly

Wife, arrived from San Fran.

82 S. Rte 2 April 25, 1951

Wife, arrived from San Fran.

423 N. 11th Street

NAME	ADDRESS	PHONE	DEATH DATE	TIME	CAUSE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10180 CERTIFICATE OF DEATH

10148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. LENGTH OF STAY IN lb <b>Since 4/58</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Frederick-Rural RD#1</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent &amp; Rest Home</b>		d. STREET ADDRESS <b>Near Mount Pleasant</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>ELIZABETH</b>	Last <b>BUCKEY</b>	4. DATE OF DEATH	Month <b>September</b>	Day <b>18,</b>	Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Sept 1883</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Hamilton Etzler</b>		14. MOTHER'S MAIDEN NAME <b>Susan Munshower</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>W. Maynard Buckey (Same as item #2)</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<b>Carcinoma of Colon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>228 N. Market St.</b>		(County) <b>Frederick, Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>58</b> , to <b>Sept 18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 18</b> , 19 <b>58</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>228 N. Market St.</b>		DATE SIGNED <b>9-19-58</b>	
ACTUAL SIGNATURE <b>B. O. Thomas</b>									
PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glade Cemetery</b>		22d. LOCATION (City, town, or county) <b>Walkersville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 2 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MISSOURI STATE DEPARTMENT OF NATURE - DIVISION OF  
WILDLIFE

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10149

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. STREET ADDRESS <u>13X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jo Ann Biardette</u>		First <u>Jo</u>	Middle <u>Ann</u>
4. DATE OF DEATH <u>Feb. 3 1958</u>		Month <u>Feb.</u>	Day <u>3</u>
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>Aug 9 1918</u>		9. AGE (In years last birthday) yrs. <u>40</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>and 37</u>	
13. FATHER'S NAME <u>Emory Biardette</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Linton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Father		Address <u>Mt. Airy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) } DUE TO (c)		Congenital Heart Disease Complete Transposition of the Great Vessels INTERVAL BETWEEN ONSET AND DEATH p. Life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7 Sept. 1958</u> , to <u>2 Feb. 1958</u> . That I last saw the deceased alive on <u>9 Sept. 1958</u> , and that death occurred at <u>7 1/2 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. H. Frederick</u> M.D. PHYSICIAN'S NAME (Type) <u>F. J. HERDRICK</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF <u>Sept. 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Pine Grove</u>
22d. LOCATION (City, town, or county) <u>Mt. Airy, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Mohrenth</u>		ADDRESS <u>Damascus, Md.</u>	24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10154

## CERTIFICATE OF DEATH

10150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Frederick</i>		a. STATE <i>MD</i> b. COUNTY <i>CARROLL</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	c. LENGTH OF STAY IN 1b <i>1 day</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i> 06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp</i>	d. STREET ADDRESS <i>Route 1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>	First <i>Thomas</i>	Middle <i>Condon</i>	4. DATE OF DEATH Month <i>Sep.</i> Day <i>1</i> Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/3/84</i>
9. AGE (In years lost birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>7</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABOYER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM.</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>W<sup>m</sup> G. CONDON</i>		14. MOTHER'S MAIDEN NAME <i>Josephine LONG</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Marion Hipsley - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infection of brain</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>	
DUE TO <i>332X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) Thrombosis of cerebral artery</i>		DUE TO <i>2 wks.</i>	
(c) Generalized arteriosclerosis		DUE TO <i>10 years</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p. m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) <i>Frederick</i> (State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>7/1</i> , 19 <i>58</i> , to <i>9/1</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/1</i> , 19 <i>58</i> , and that death occurred at <i>11:55 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V Chase</i>		ADDRESS (Street, city or town, state) <i>4 E. Church St</i> DATE SIGNED <i>9/2/58</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-4-58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Sykesville, Carroll, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gilbert H. Haight Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 4 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10151

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10181

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Frederick</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>John</b>	Middle <b>Everett</b>	Lost	4. DATE OF DEATH <b>September 13 1958</b>	Month <b>September</b>	Day <b>13</b>	Year <b>1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1900</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaners</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>S. Leslie Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Bertha M. Griffin</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1922-1925</b>		17. INFORMANT <b>Teresa Murry Cooper</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>420.1</b> 10 min.									
Conditions, if any, which gave rise to immediate cause (b) (a), stealing the underlying cause lost. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B.O.Thomas</i>		DATE SIGNED <i>Sept 15, 1958</i>							
EXAMINER'S NAME (Type) <b>Dr. B.O.Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E.Cline &amp; Son</i>		24a. REC'D BY REGISTRAR <b>Arthur S. Krause</b>							
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>							
		DATE SEP 16 '58							

WISCONSIN STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
WISCONSIN

NAME  
ADDRESS

DECEASED -

NAME  
ADDRESS

DECEASED -

NAME  
ADDRESS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1, Film G234, 10/10/58 Icy

Reg. Dist. No. 10297

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 72 hours after death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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15

2

## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>	10155 Frederick MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyettstown</u> Frederick	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyettstown</u> Hyattstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u>	First <u>Franklin</u>	Middle <u>Curtis</u>	4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 7, 1938</u> 19 yrs.
9. AGE (In years last birthday)	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>William Curtis</u>		
14. MOTHER'S MAIDEN NAME <u>Elie Trotter</u>	Address <u>William Curtis Hyettstown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO.			
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured liver</u> DUE TO <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound fracture of left thigh and leg</u> DUE TO (c) <u>Compound fracture of right ankle</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apperant struck by automobile</u>			
20c. TIME OF INJURY Hour <u>5</u> a.m. Month, Day, Year <u>9/27/58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Route 355</u>	20f. (City or town) <u>Hyettstown</u> (County) <u>Md</u> (State) <u>Montgomery</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B.O.Thomas</u>	DATE SIGNED		
EXAMINER'S NAME (Type) <u>B.O.Thomas, M.D.</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	22d. LOCATION (City, town, or county) <u>Rockville</u> , (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>	ADDRESS <u>Rockville, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>

WISCONSIN STATE BOARD OF EXAMINERS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-2142

NAME OF PERSON DIED: JOHN W. HANNAH

ADDRESS: 101 N. 10TH ST., MILWAUKEE, WIS.

AGE: 65 YEARS

SEX: MALE

RACE: WHITE

RELIGION: CATHOLIC

EDUCATION: GRAVES

EMPLOYMENT: UNEMPLOYED

DEATH OCCURRED ON: NOVEMBER 10, 1958

DEATH OCCURRED AT: HOME

DEATH OCCURRED FROM: HEART DISEASE

DEATH OCCURRED IN: CITY OF MILWAUKEE

DEATH OCCURRED IN: STATE OF WISCONSIN

DEATH OCCURRED IN: UNITED STATES

DEATH OCCURRED IN: NORTH AMERICA

DEATH OCCURRED IN: CIVILIAN LIFE

DEATH OCCURRED IN: NOT IN MILITARY SERVICE

DEATH OCCURRED IN: NOT IN POLICE OR FIRE DEPARTMENT

DEATH OCCURRED IN: NOT IN ARMY, NAVY, MARINES, COAST GUARD, OR AIR FORCE

DEATH OCCURRED IN: NOT IN AIRPORT OR AIRPORT TERRITORY

DEATH OCCURRED IN: NOT IN AIRPORT TERMINAL

DEATH OCCURRED IN: NOT IN AIRPORT AIRPORT TERRITORY

DEATH OCCURRED IN: NOT IN AIRPORT AIRPORT TERMINAL

DEATH OCCURRED IN: NOT IN AIRPORT AIRPORT AIRPORT TERRITORY

DEATH OCCURRED IN: NOT IN AIRPORT AIRPORT AIRPORT TERMINAL

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DEATH OCCURRED IN: NOT IN AIRPORT AIRPORT AIRPORT AIRPORT AIRPORT AIRPORT TERMINAL

10152

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm FM3. Page 5 may be retained for State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Reg. Dist. No.									
10182											
1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE Maryland		c. COUNTRY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural--Mt. Airy		c. LENGTH OF STAY IN 1b		3 wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Rural-- Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Woodville		d. STREET ADDRESS		R.D. 1 , Central		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First CHARLES		Middle R.		Last DUVALL		4. DATE OF DEATH		Month 9- Year 1958	
5. SEX		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-4-1941		9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		farm laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME		LeRoy Duvall		14. MOTHER'S MAIDEN NAME		Nettie E. Shaffer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-38-1055		17. INFORMANT Mr. LeRoy Duvall, Same		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Crushed chest									
912.1 DUE TO Conditions, if any, which gave rise to immediate cause (b)		INTERVAL BETWEEN ONSET AND DEATH Minutes									
(c) DUE TO (d), stating the underlying cause first.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm Tractor upset									
20c. TIME OF INJURY Month, Day, Year Hour 3 P.M. p.m. 9-19 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Woodville, Frederick, Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>B.C. Thomas</i>		DATE SIGNED 9-19-158									
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1958		22c. NAME OF CEMETERY OR CREMATORIUM Locust Grove		22d. LOCATION (City, town, or county) Frederick Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>					

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10153

FOR STATE  
HEALTH DPT.

Reg. Dist. No.

10156

Items 2,3 Film 0231 9/21/58 recd

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
<i>FREDERICK</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel Frederick</i>		c. LENGTH OF STAY IN 1b <i>5 Days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		e. STREET ADDRESS <i>Frederick, Md 1961</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
<i>Elna First Hilton Middle Fike</i>		Lost	9 9 1958
5. SEX		6. COLOR OR RACE	
Female white		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH <i>Nov 15 1900</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years from birthday) <i>57 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>J B Hilton</i>		14. MOTHER'S MAIDEN NAME <i>Arlene Belle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lester &amp; Fike</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushed chest</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by automobile</i>	
20c. TIME OF INJURY Month, Day, Year Hour _____ p.m. <i>9/9 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i> 20f. (City or town) (County) (State) <i>Burkittsville Frederick Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. L. Thomas</i>		DATE SIGNED <i>Sept. 9, 1958</i>	
EXAMINER'S NAME (Type) <i>B. L. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-15-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Terra Alta W Va</i>		22d. LOCATION (City, town, or county) (State) <i>Middleton</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray &amp; Gladhill</i>		24a. REC'D BY REGISTRAR <i>SEP 16 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

WISCONSIN STATE DEPARTMENT OF MIGRATION - SAVINOME  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
WISCONSIN

DEATH  
CERTIFICATE  
EXAMINER

DEATH CERTIFICATE

NAME

ADDRESS

AGE

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF EXAMINER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10157

## CERTIFICATE OF DEATH

Reg. Dist. No.

10154

1. PLACE OF DEATH o. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick				o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Rural	1 day		Thurmont		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS.				
Frederick Memorial Hospital	/				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Charles	F.	Firor		Sep	5 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (on birthday) yrs.)	IF UNDER 1 YEAR Months Days Hours Min.
M	W		Oct. 28, 1882	75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Carpenter	Self-employed	Maryland	U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
Benjamin Firor	Amanda Lightner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
	Lost	Mrs. Jessie S. Firor	Thurmont, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Coronary thrombosis with myocardial infarction</u> 1 day (c) <u>arteriosclerotic Heart Disease</u> 10 yrs +			4 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>9/4</u> , 1958, to <u>9/5</u> , 1958, that I last saw the deceased alive on <u>9/4</u> , 1958, and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Henry V. Chase</u>	M.D.	ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>9/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>	<u>Frederick Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-8-58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>United Brethren Cem.</u>	22d. LOCATION (City, town, or county) <u>Thurmont, Maryland</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>	ADDRESS <u>Thurmont, Md.</u>	24a. REG'D BY REGISTRAR <u>SEP 10 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 [STATEMENT OF MARCH 1978](#) — [STATEMENT OF MARCH 1979](#)

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10158

## CERTIFICATE OF DEATH

Reg. Dist. No.

10155

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		b. COUNTY <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. CITY OR TOWN (If not in hospital, give street address) OR INSTITUTION <b>115 East Second Street</b>		d. STREET ADDRESS <b>115 East Second Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VALLIE</b>		First <b>RAMSBURG</b>	Middle <b>FISHER</b>
4. DATE OF DEATH <b>September 16, 1958</b>		Month <b>September</b>	Day <b>16</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>November 29, 1885</b>		9. AGE (In years (at birthday) yrs.) <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Thomas Ramsburg</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Claggett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-5058</b>	17. INFORMANT Address <b>Mr. Alden E. Fisher, Frederick R.D.#2, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
<i>Coronary Thrombosis</i> <i>Gastric-splenitis Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1958</b> , to <b>Sept 16, 1958</b> , that I last saw the deceased alive on <b>Sept 16, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>West Third Street</b> DATE SIGNED <b>9/17/58</b>			
ACTUAL SIGNATURE <i>Thomas E. Stone</i>		PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Stone</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 18, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>
22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>Sept 18 '58</b>	24b. REGISTRAR'S SIGNATURE <i>C. Etchison</i>

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
JOHN D. HARRIS	65	M	12/12/1999	10:00 AM	Cardiac Arrest	1234567890
ADDRESS OF DECEASED						
123 Main Street, Anytown, USA						
CITY, STATE, ZIP CODE						
Anytown, USA, 12345						
PHONE NUMBER						
(555) 123-4567						
RELATIONSHIP TO DECEASED						
Son						
NAME OF DOCTOR						
Dr. John Doe, MD						
SIGNATURE OF DOCTOR						
John Doe, MD						
DATE OF SIGNATURE						
12/12/1999						

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the buritontis permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10159 CERTIFICATE OF DEATH

10156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN lb <b>20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEM. HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GARY</b>	Middle <b>RICHARD</b>	Last <b>FLOHR</b>
4. DATE OF DEATH	Month <b>Sept.</b>	Day <b>7</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1958</b>
9. AGE (In years lost birthday) yrs. <b>2</b>	10. IF UNDER 1 YEAR Months <b>2</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME <b>KENNETH MONROE FLOHR</b>		14. MOTHER'S MAIDEN NAME <b>ELsie VIRGINIA LAMM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hyaline Membrane</b> INTERVAL BETWEEN ONSET AND DEATH 773.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9-5</b> , 19 <b>58</b> , to <b>9-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9-7</b> , 19 <b>58</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Fred J. Heidrich</i>	M.D.	ADDRESS (Street, city or town, state) <b>220 N. MARKET ST</b>	DATE SIGNED <b>9-8-58</b>
PHYSICIAN'S NAME (Type) <b>F. J. HEIDRICH</b>	<i>Heidrich Fred</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-8-1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>M. OLIVET Cemetery</b>	22d. LOCATION (City, town, or county) <b>FREDERICK - MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Clive &amp; Son</i>	ADDRESS <i>Frederick Md.</i>	24a. REC'D BY REGISTRAR DATE <b>SEP 9 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10157

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		10160									
		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
		MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
		Frederick		a. STATE Maryland							
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Frederick							
		Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Mt Airy R.F.D. 4							
		Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
		3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
		William		Ambriose	Fogle		September	27	19	58	
		5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
		Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 8, 1895	63 yrs.	Months	Days	Hours	
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
		Laborer		Wood MFG.		Frederick Co.		U.S.A.			
		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
		Samuel S. Fogle		Cecilia Marton							
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		No		214-28-1086		Mrs William Fogle Mt Airy R.F.D. 4					
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Cerebral Contusion		INTERVAL BETWEEN ONSET AND DEATH			
		9030		DUE TO				5 hours			
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO		T Laceration					
		(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Fall off porch striking head on metal can					
		20c. TIME OF INJURY Month, Day, Year Hour p.m. 9/27 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Same			(City or town) Mt Airy R.F.D. 4 Frederick Md (County) (State)		
		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
		ACTUAL SIGNATURE <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED		
		EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 9/30/58		22b. DATE THEREOF 9/30/58		22c. NAME OF CEMETERY OR CREMATORIUM METHODIST CEM		22d. LOCATION (City, town, or county) Taylorsville MD		(State)	
		22e. FUNERAL DIRECTOR'S SIGNATURE <i>D. O. Hartzer &amp; Sons, New Windsor Md</i>		ADDRESS		24a. REC'D BY REGISTRAR SEP 30 '58		24b. REGISTRAR'S SIGNATURE <i>Clothing &amp; Thrift</i>			

DETAILED EXPLANATION OF THE PLAN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11297

10161

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
Frederick MARYLAND		Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Frederick	4 days	35 Brunswick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
Frederick Memorial Hospital		20 East "C" Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
	Charles	Alfred	Fowler			
4. DATE OF DEATH	Month	Day	Year			
	Sept.	30	1958			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1924	9. AGE (In years lost birthday) 34 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
M	W					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Railroad		Brakeman		Maryland		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			
Virgil Fowler			Regie Kelley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
Unknown				Mrs. Ruth Fowler Brunswick, Maryland		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Pneumonia, t.i.s 202.1						
INTERVAL BETWEEN ONSET AND DEATH 45 days						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.						
DUE TO (b) Disseminated Giant Follicle Lymphoblastoma 8 years						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
19						
21. I certify that I attended the deceased from Oct. 1956, to Sept. 30, 1958, that I last saw the deceased alive on Sept. 29, 1958, and that death occurred at 11:05 AM, from the causes and on the date stated above.						
ADDRESS (Street, city or town, state)						
DATE SIGNED						
ACTUAL SIGNATURE		Thomas R. Reid, M.D. Professional Bldg., Frederick, Md.				
PHYSICIAN'S NAME (Type)		Thomas R. Reid				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)
Burial		10-3-1958		Park Heights		(State)
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. RECEIVED BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
B. Lee Feit		Brunswick, Maryland		Oct 9 1958		Arthur S. Thoms.
DATE						



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10162

## CERTIFICATE OF DEATH

Reg. Dist. No.

10158

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovettsville 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) RAYMOND		First H. Middle FRYE	4. DATE OF DEATH Month September Day 3, Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Oct 1898
9. AGE (In years last birthday) yrs. 59		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Butler L. Frye		14. MOTHER'S MAIDEN NAME Rosa Grubb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 578-14-8390	
17. INFORMANT		Address Mrs. Essie Frye (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture of the myocardium</i> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis with myocardium</i> DUE TO <i>infarction</i> 1 wh (c) <i>Arteriosclerotic Heart disease</i> 5 yrs +			
INTERVAL BETWEEN ONSET AND DEATH 5-10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1, 1958, to 9/3, 1958, that I last saw the deceased alive on 9/3, 1958, and that death occurred at 1:30P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry V. Chase</i>		ADDRESS (Street, city or town, state) 4 East Church Street M.D.	
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		DATE SIGNED 9/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58	
22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		22d. LOCATION (City, town, or county) Lovettsville, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR SEP 5 '58	
		24b. REGISTRAR'S SIGNATURE <i>Orion S. Kraus</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10176

### CERTIFICATE OF DEATH

10159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b <b>70 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		d. STREET ADDRESS <b>815 N. Maple Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>815 N. Maple Ave.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lillie</b>	Middle <b>Elizabeth</b>	Last <b>Gladstone</b>	4. DATE OF DEATH	Month <b>9</b>	Day <b>-23</b>	Year <b>19 58</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-1870</b>	9. AGE (In years from birthdate) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Shry</b>				14. MOTHER'S MAIDEN NAME <b>Prucilla Mc Kimmey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Mrs. Bessie Hoffner, Brunswick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>9/6/58</b>  <b>9/6/58</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/6</b> , 19 <b>58</b> , to <b>9/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/21</b> , 19 <b>58</b> , and that death occurred at <b>Brunswick</b> , 19 <b>58</b> , from the causes and on the date stated above.  ACTUAL SIGNATURE <b>J. G. F. Smith</b>		ADDRESS (Street, city or town, state) <b>Brunswick, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Union</b>		22d. LOCATION (City, town, or county) (State) <b>Lovettsville, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Lee Feete</b>		ADDRESS <b>B. Lee Feete, Brunswick, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Orville S. Krause</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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WYOMING STATE BOARD OF MINES AND GEOLOGY  
DEPARTMENT OF NATURAL RESOURCES

STATE OF WYOMING

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 233 9-22-58 ams

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>25 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memoria Hospital</b>		d. STREET ADDRESS <b>909 Motter Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LENA</b>		Middle <b>Lena</b>		HAINES		4. DATE OF DEATH <b>September 10, 1958</b>	Month Day Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 8, 1897</b>	
9. AGE (In years at birthday) <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		12. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Burke</b>		14. MOTHER'S MAIDEN NAME <b>Annie Snyder</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5006</b>	
17. INFORMANT <b>Mr. Charles LeR. Haines-Same as Item #2</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 12, 1958</b> , to <b>Sept 10, 1958</b> , that I last saw the deceased alive on <b>Sept 10, 1958</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Thomas E Stone</b> M.D. ADDRESS (Street, city or town, state) <b>4 W 3rd St</b> DATE SIGNED <b>9-10-58</b>							
PHYSICIAN'S NAME (Type) <b>Thomas E STONE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS		24a. REG'D BY REGISTRAR <b>SEP 15 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Thomas E. Stone</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Name of deceased		Date of birth		Cause of death	
John W. HARRIS		1870-08-01		Diseased	
Age at time of death		Place where deceased resided		Name of physician	
80 years		Baltimore, Maryland		Dr. J. C. HARRIS	
Occupation		Name of hospital		Name of funeral home	
Retired		Baltimore City Hospital		Harrington & Son	
Residence		Date of death		Time of death	
1000 Locust Hill Avenue		1950-08-01		12:00 P.M.	
City, State		County		State	
Baltimore, Maryland		Baltimore		Maryland	
Signature of physician		Signature of coroner		Signature of funeral director	
Dr. J. C. HARRIS		Coroner		Harrington & Son	
Title		Title		Title	
Physician		Coroner		Funeral Director	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10184

10162

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Middleton, Md. R #2</b> COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen, Md.</b>		c. LENGTH OF STAY IN lb <b>412 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Middleton, Route # 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hosp.</b>		d. STREET ADDRESS <b>Cullen, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Vincent</b>	Last <b>HANCOCK</b>	4. DATE OF DEATH <b>September 1 1958</b>	Month Day Year		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>Aug. 8, 1898</b>	9. AGE (In years lost, birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Orderly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Willie Hancock</b>		14. MOTHER'S MAIDEN NAME <b>Mary Butler</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>577-12-2971</b>		17. INFORMANT <b>Hospital Chart, Cullen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One day.</b>					
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>002X</b>		26 Yrs.					
(b) DUE TO  Rheumatic Fever (1932)		8 Yrs.					
(c) DUE TO  Moderately Advanced Pul. Tuberculosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>of work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 16, 1957</b> , to <b>Sept 1, 1958</b> , that I last saw the deceased alive on <b>Sept. 1 1958</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>T. F. Vestal</b>		M.D. <b>September 1, 1958</b>					
PHYSICIAN'S NAME (Type) <b>T. F. Vestal, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Cemetery</b>		22d. LOCATION (City, town, or county) <b>Middleton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray C. McCallum</b>		ADDRESS <b>Middleton</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knobell</b>	

## CERTIFICATE OF DEATH

NAME

DATE OF DEATH

DECEASED PERSON'S PREVIOUS ADDRESS

TIME AND PLACE OF DEATH

DECEASED PERSON'S OCCUPATION

DECEASED PERSON'S AGE

DECEASED PERSON'S GENDER

DECEASED PERSON'S RACE

DECEASED PERSON'S RELIGION

DECEASED PERSON'S MARRITAL STATUS

DECEASED PERSON'S EDUCATION

DECEASED PERSON'S OCCUPATIONAL HISTORY

DECEASED PERSON'S MEDICAL HISTORY

DECEASED PERSON'S HABITS

DECEASED PERSON'S HABITUAL DRINKING

DECEASED PERSON'S HABITUAL DRUGS

DECEASED PERSON'S HABITUAL SMOKING

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10164

## CERTIFICATE OF DEATH

Reg. Dist. No.

10163

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b <b>over 60 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>210 South Market St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Augustus Edward Heidler</b>		First	Middle
4. DATE OF DEATH		Month	Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 10-1869</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Cigar Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Heidler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Heidler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-5336</b>	
17. INFORMANT		Address <b>Maryland Mrs. Nola Soper-210 S. Market St.-Frederick-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Generalized arterio sclerosis</b> 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arterio sclerotic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 27</b> , 19 <b>58</b> , to <b>Sept. 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 23</b> , 19 <b>58</b> , and that death occurred at <b>12:05 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ralph L. Michels</b> , M.D. PHYSICIAN'S NAME (Type) <b>Dr. Ralph L. Michels</b>			
ADDRESS (Street, city or town, state) <b>Frederick Shopping Center</b> DATE SIGNED <b>9-26-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Cline &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '58</b>	
ADDRESS <b>Frederick-Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. FROM FLA.—HORN TO THE STATE QUADRANT.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
10185

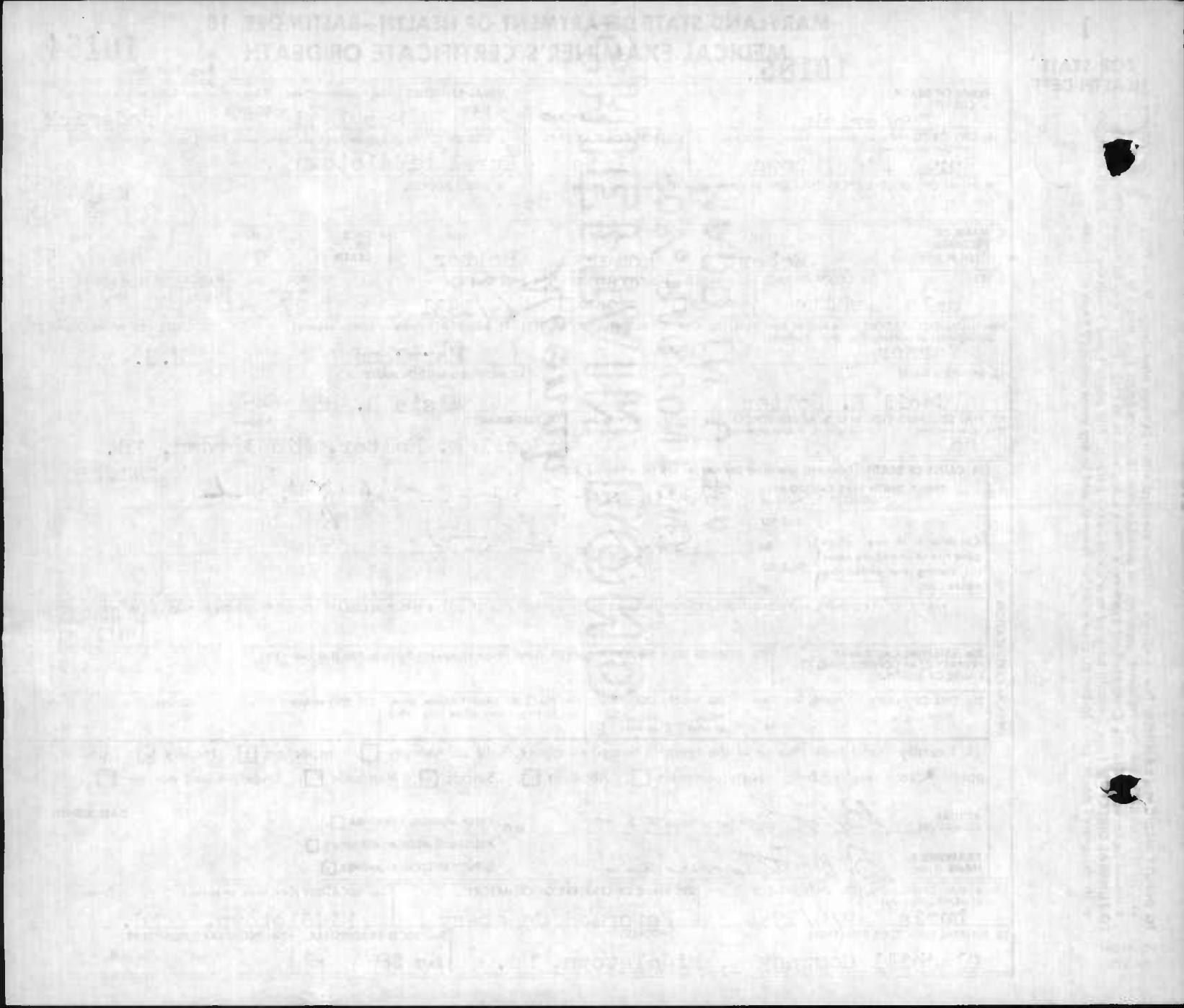
10164

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for my files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>Homer</b>	Last <b>Holter</b>	4. DATE OF DEATH Month <b>9</b>	Month <b>4</b>	Day <b>19</b>	Year <b>58</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/4/1931</b>	9. AGE (In years from birthday) <b>27</b> yrs.	10. UNDER 1YEAR Months <b>0</b>	11. UNDER 24 HRS. Days <b>0</b>	12. UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Cecil K. Holter</b>		14. MOTHER'S MAIDEN NAME <b>Elsie R. Remsberg</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT			
				Cecil k. Holter, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976 X</b> DUE TO <b>Gun shot wound of head</b> INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO <b>Self inflicted</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9/6/1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) <b>Middletown, Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Thorne</b>	24b. REGISTRAR'S SIGNATURE				
		DATE <b>SEP 8 '58</b>					



1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10165

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for 2 years.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy Route 1 ... Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ijamsville .. Frederick County</b>		d. STREET ADDRESS <b>Mt. Airy</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Wilbert McKinley Hoy</b>		First	Middle
4. DATE OF DEATH <b>September 27 1958</b>		Lost	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1898</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmers Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co.-Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph Hoy</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Stanton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Clifton Hoy .. 128 East St. Fred. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) (d) (e) (f) DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>10 min. to</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <b>Sept. 30, 1958</b>	
ACTUAL SIGNATURE <b>B.O.Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O.Thomas Sr.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodville Fred. Co. Md.</b>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-30-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodyville</b>	24a. REC'D BY REGISTRAR DATE OCT 1 '58
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III Frederick, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

WISCONSIN STATE MEDICAL EXAMINER'S  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STAR

SEARCHED	INDEXED	SERIALIZED	FILED
DECEASED PERSON			
NAME			
ADDRESS			
AGE			
SEX			
MATERIAL TESTED			
TESTS			
CAUSE OF DEATH			
DEATH CERTIFIED			
SIGNATURE			
STAMP			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10165

## CERTIFICATE OF DEATH

Reg. Dist. No.

10166

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
FREDERICK MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b FREDERICK MOST OF LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS FREDERICK, MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First HARRY	Middle ROY
4. DATE OF DEATH		Month SEPT.	Day 18,
5. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. B. DATE OF BIRTH		8. AGE (In years lost birthday) yrs.	
1-4-81		77 yrs.	
9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS.	
Months 8		Days 14 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Lewis Kolb.		14. MOTHER'S MAIDEN NAME Margaret Catherine MacGruder.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-03-7125	
17. INFORMANT		Address Mrs. Sarah Mealey, 8417, Dixon Ave. Silver Sp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
561.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Intestinal Obstruction	
(b)		3 yrs.?	
DUE TO Diseased Hemia			
(c)		16 yrs.	
DUE TO Inflammation of Liver and abdomen following Resection of Stomach			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Insufficiency - New Lobar Pneumonia - Bronchitis - Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1958, to Sept. 18, 1958, that I last saw the deceased alive on Sept. 17, 1958, and that death occurred at 4:50 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick - Md.	
ACTUAL SIGNATURE Frank D. Worthington		DATE SIGNED	
PHYSICIAN'S NAME (Type) FRANK D. WORTHINGTON, MD.		FREDERICK, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 20, 1958.	
22c. NAME OF CEMETERY OR CREMATORIUM MT OLIVET CEMETERY		22d. LOCATION (City, town, or county) FREDERICK, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME		24a. REG'D BY REGISTRAR SEP 23 1958	
ADDRESS FREDERICK MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Haas	

87-3801-A

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>										10167		
<b>CERTIFICATE OF DEATH</b>										Reg. Dist. No.		
<b>1. PLACE OF DEATH</b> a. COUNTY      Frederick      MARYLAND					<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE      Maryland      b. COUNTY      Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 15 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wynelle Nursing Home					d. STREET ADDRESS / 215 East Third Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print)		First ANNIE	Middle M.	Last KUNKLE	<b>4. DATE OF DEATH</b> Month September Day 3, Year 1958							
<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> January 1, 1874		<b>9. AGE (In years last birthday) yrs.</b> 84		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Domestic					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> At Home		<b>11. BIRTHPLACE (State or foreign country)</b> Penna.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA			
<b>13. FATHER'S NAME</b> Harmon Nary					<b>14. MOTHER'S MAIDEN NAME</b> Clara Gordon							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)      No					<b>16. SOCIAL SECURITY NO.</b> None		<b>17. INFORMANT</b> Mrs. Frank L. Gastley-Same as Item #2		Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X      Cerebral Thrombosis DUE TO										1 day		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Generalized arteriosclerosis										3 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X      Diabetes Mellitus										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Doy, Year Hour o. m.      p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> West Third Street		<b>20f. (City or town)</b> Frederick, Maryland		<b>(County)</b> Frederick County		<b>(State)</b> Maryland		
<b>21. I certify that I attended the deceased from</b> <u>Jan 1, 1958</u> <b>to</b> <u>Sept 3, 1958</u> <b>that I last saw the deceased alive on</b> <u>Sept 3, 1958</u> , <b>and that death occurred at</b> <u>6:15 P.M.</u> <b>M., from the causes and on the date stated above.</b> <b>ADDRESS (Street, city or town, state)</b> <u>West Third Street,</u> <b>M.D.</b> <b>ACTUAL SIGNATURE</b> <u>Thomas E. Stone</u> <b>DATE SIGNED</b> <u>9/5/58</u>												
<b>PHYSICIAN'S NAME (Type)</b> Dr. Thomas E. Stone		<b>Frederick, Maryland</b>										
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>22b. DATE THEREOF</b> Sept. 6, 1958		<b>22c. NAME OF CEMETERY OR CREMATORIUM</b> Kutz Church Cemetery		<b>22d. LOCATION (City, town, or county)</b> Cumberland County, Penna.		<b>(State)</b>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> M. R. Etchison & Son, Frederick, Maryland					<b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> SEP 8 '58		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Krause</u>			

WISCONSIN STATE GOVERNMENT

CERTIFICATE OF MAIL

REGULAR

REGULAR

REGULAR



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10167

## CERTIFICATE OF DEATH

Reg. Dist. No. 10168

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN lb <b>4 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keymar</b>			d. STREET ADDRESS <b>06 X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Guy</b>			First <b>Baxter</b>	Middle <b>Lynn</b>	Lost	4. DATE OF DEATH <b>September 10, 1958</b>	Month <b>September</b>	Day <b>10</b>	Year <b>1958</b>			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1867</b>			9. AGE (In years lost birthday) <b>91</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b>		Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Abram Lynn</b>			14. MOTHER'S MAIDEN NAME <b>Mary Dorsey</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Earl Lynn, Westminster, Maryland</b>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33 IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			<i>Cerebral Hemorrhage, Males</i>			INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 10, 1958</b> to <b>Sept 10, 1958</b> that I last saw the deceased alive on <b>Sept 10, 1958</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			ADDRESS (Street, city or town, state)						DATE SIGNED			
ACTUAL SIGNATURE <i>John H. Messler, M.D.</i>			M.D.						<b>Sept 11 1958</b>			
PHYSICIAN'S NAME (Type) <b>John H. Messler, M.D.</b>												
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Sept. 13, 1958</b>			22c. NAME OF CEMETERY OR CREMATORIUM <b>Haugh's Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Ladiesburg, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion C. Fuss</i>			ADDRESS <b>C.O. Fuss &amp; Son, Taneytown, Md.</b>			24a. REC'D BY REGISTRAR <b>SEP 15 '58</b>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

## CERTIFICATE OF DEATH

Reg. Dist. No.

10169

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN lb <b>1 mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK Memorial</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>" FREDERICK</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT LEE</b>		First <b>MAIN Jr.</b>	Middle <b>MAIN Jr.</b>
4. DATE OF DEATH <b>Sept</b>		Last <b>Sept</b>	Month <b>10</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>18 Aug '58</b>		9. AGE (In years last birthday) <b>yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert L. Main Sn</b>		14. MOTHER'S MAIDEN NAME <b>charlotte J. Engle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Robert L. Main, Sr.—Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis, acute</b>			
DUE TO <b>491X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO <b>BRONCHOPNEUMONIA, PROB. VIRAL</b>			
C (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Sept</b> , 1958, to <b>10 Sept</b> , 1958, that I last saw the deceased alive on <b>10 Sept</b> , 1958, and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. L. Guest</b>		ADDRESS (Street, city or town, state) <b>7 E. Church St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. R. L. Guest</b>		DATE SIGNED <b>10 Sept 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 15 '58</b>	
ADDRESS <b>2069171 XV6</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

84 EDITIONS—171000 CIRCULATIONS STATE OWNERSHIP

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10187

10170

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Frederick Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen, Md.</b>		c. LENGTH OF STAY IN lb <b>9 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Rt. # 2</b>		d. STREET ADDRESS <b>Wms. Rd.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Archie D. NIXON</b>		First	Middle	Last	4. DATE OF DEATH <b>Sept. 27</b>	Month	Day	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 - 25 - 1898</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland Cement &amp; Sup. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Elwood Nixon</b>		14. MOTHER'S MAIDEN NAME <b>Estella Twigg.</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-05-7055</b>		17. INFORMANT <b>Hospital Chart</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far Advanced</b>		INTERVAL BETWEEN ONSET AND DEATH <b>? ?</b>						
002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cirrhosis of Liver								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of Liver</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>9-18</b> , 19 <b>58</b> to <b>9-27-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9 - 27</b> , 19 <b>58</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>T. F. Vestal</b>		ADDRESS (Street, city or town, state) <b>9-27-58</b> DATE SIGNED						
PHYSICIAN'S NAME (Type) <b>T. F. Vestal, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sunset Mem. Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland,</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Right</b>		ADDRESS <b>Cumb. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Trahan</b>		
		<b>311 Decatur St.</b>						

## CALIFORNIA STATE DEPARTMENT OF HEALTH - SAN FRANCISCO

## CERTIFICATE OF DEATH

No. 100

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Attorney

Name of Lawyer

Name of Notary Public

Name of Sheriff

Name of Probate Court

Name of Clerk

Name of Sheriff's Office

Name of Sheriff's Deputies

Date

Year

Month

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10188

## CERTIFICATE OF DEATH

10171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Frederick				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		Md Frederick	
Boonsboro		4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Reeders Nursing Home		Sabillasville			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Nellie		May	Overcash	Sept 4	1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 69 yrs.	# UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
Female	White		Aug 7, 1889		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Myersville Md U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Baker		Florence Bowser		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or date of service)				Glenn L. Overcash, Sabillasville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO 5 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral paraparesis - (c) 3 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 15, 1958, to Sept 4, 1958, that I last saw the deceased alive on Sept 4, 1958, and that death occurred at 2 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE G.W. LeVan M.D. Boonsboro 9/4/58					
PHYSICIAN'S NAME (Type) G.W. LeVan 9/4/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/7/58		22c. NAME OF CEMETERY OR CREMATORIAL Green Hill	
22d. LOCATION (City, town, or county) Waynesboro Franklin Co		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove Waynesboro, Pa.		ADDRESS		24a. REC'D BY REGISTRAR SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10169

## CERTIFICATE OF DEATH

10172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Graceham</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>John</b>	Middle <b>B</b>	Last <b>Pittenger</b>	4. DATE OF DEATH Month <b>Sept.</b>	Day <b>22</b>	Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 20, 1868</b>	9. AGE (In years from last birthday) <b>90 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during whole working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jeremiah Pittenger</b>		14. MOTHER'S MAIDEN NAME <b>Anna Martin</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James. G. Pittenger</b>		Address <b>Philadelphia, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		Uremia and Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arterosclerotic Heart Disease and Chronic Nephrosclerosis</b>		(b) Arterosclerotic Heart Disease and (c) Chronic Nephrosclerosis		yrs <b>0</b>			
DUE TO		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of Neck rt Femur</b>		1 mo. ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell at home</b>					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <b>Sept. 22, 1958</b> , and that death occurred at <b>6:00P</b>		Aug. 22, 1958, to Sept. 22, 1958		that I last saw the deceased ADDRESS (Street, city or town, state) <b>7 W. 3rd st Frederick, Md</b>			
ACTUAL SIGNATURE <b>Frank Damazo M.D.</b>		DATE SIGNED <b>9/22/58</b>					
PHYSICIAN'S NAME (Type) <b>Frank Damazo M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Graceham Moravian Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Graceham, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Maryland</b>		24a. REG'D BY REGISTRAR DATE <b>SEP 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knau</b>	

## CERTIFICATE OF DEATH

DECEASED PERSON'S NAME John Doe	SEX Male	AGE 55 years	TIME OF DEATH 11:00 AM	PLACE OF DEATH Home
ADDRESS 123 Main Street	NAME OF DOCTOR Dr. John Smith	NAME OF HOSPITAL General Hospital	NAME OF FUNERAL DIRECTOR Funeral Home	NAME OF CEMETERY Cemetery
REASON FOR DEATH Heart attack				
DATE OF DEATH May 1, 1999				
SPECIAL INSTRUCTIONS None				
PRINTED NAME OF SIGNER John Doe				
SIGNATURE OF SIGNER 				
DATE OF SIGNATURE May 1, 1999				

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10189

## CERTIFICATE OF DEATH

Reg. Dist. No.

10173

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland		c. LENGTH OF STAY IN 1b 392 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills, Maryland		d. STREET ADDRESS none			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Malcolm	Middle E.	Last Pyles	4. DATE OF DEATH September 22, 1958	Month September	Day 22	Year 1958	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 23, 1908	9. AGE (In years from birth) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Franklin W. Pyles		14. MOTHER'S MAIDEN NAME Roberta (unknown last name)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-05-9493		17. INFORMANT Records of Victor Cullen State Hosp.; Cullen, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced Pulmonary Tuberculosis, Active</u>						INTERVAL BETWEEN ONSET AND DEATH			
<u>002X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <u>Pulmonary Hypertension</u> Emphysema							
		(c) <u>Cardiac Failure</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D. C.	(County)	(State)	
21. I certify that I attended the deceased from Aug. 26, 1957, to Sept. 22, 1958, that I last saw the deceased alive on Sept. 21, 1958, and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <u>T.F. Vestal.</u>	M.D.		Victor Cullen State Hospital						
PHYSICIAN'S NAME (Type) T.F. Vestal, M.D.; Superintendent	Cullen, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-25-58	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.		22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Clegg - Thurmont, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 23 '58	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10170 CERTIFICATE OF DEATH

Reg. Dist. No.

10174

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USA Medical Unit, Ft Detrick, Md.				d. STREET ADDRESS 40 East 3rd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Harry	Middle Melvin	Last Shipley, Sr.	4. DATE OF DEATH	Month Sept.	Day 3	Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 5	Hours 8 Min. -
Male Cau.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		28 May 1897				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harry Franklin Shipley				14. MOTHER'S MAIDEN NAME Fanny Easterday				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT 17942-27757 214-10-5460H Harry M. Shipley, Jr., Springfield, Va.				Address 6001 Charlotte St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Mycardial infarction				INTERVAL BETWEEN ONSET AND DEATH Immediately		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Arteriosclerosis, severe, generalized				3 years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Previous Pulmonary Embolic						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 9 June 1958, to 3 Sep. 1958, that I last saw the deceased alive on 3 Sep. 1958, and that death occurred at 6:00 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE Richard B. Hornick						ADDRESS (Street, city or town, state) DATE SIGNED M.D. USA Medical Unit, Ft. Detrick, Md.—3 Sep 58		
PHYSICIAN'S NAME (Type) RICHARD B. HORNICK, Captain, MC								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick,		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hause		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10171

Item 9 Film G233 9-11-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

10175

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY	Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		c. LENGTH OF STAY IN 1b		1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Brunswick 35					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital		d. STREET ADDRESS		9 North 10th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		John B. Spurrier		First Middle		Last		4. DATE OF DEATH		Month	Day	Year			
S. SEX		M ale		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		Sep 4 1958			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Engineer		10b. KIND OF BUSINESS OR INDUSTRY		B.&O.R.R.Co		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		Maryland U.S.A.			
13. FATHER'S NAME		John H. Spurrier		14. MOTHER'S MAIDEN NAME		Laura Beall		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		Yes World War I		16. SOCIAL SECURITY NO.		Edward H. Spurrier, Brunswick, Maryland		Months		Days		Hours Min.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion 420.1 DUE TO										INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Cerebral Ischemia, severe DUE TO										3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Hypertensive Cardiovascular Disease, 6 yrs +										6 yrs +			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE		Henry V. Chase M.D. 4 E. Church St										DATE SIGNED 9/4/58			
PHYSICIAN'S NAME (Type)		Henry V. Chase Frederick, Maryland										ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		9-6-1958		22c. NAME OF CEMETERY OR CREMATORIAL		Marvin Chapel		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE		B. Lee Feete Brunswick, Maryland										24a. REC'D BY REGISTRAR DATE		Plain #4 Maryland	
												SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Mann	

MANUFACTURED STATE DEVELOPMENT AUTHORITY - BIRMINGHAM - 19

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10172

## CERTIFICATE OF DEATH

10176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Jefferson Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Armatha	Middle S.	Last Stern	4. DATE OF DEATH	Month September	Day 20	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH September 17, 1905	9. AGE (In years lost birthday) 53 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done Reg. Nurse Reg. most nursing life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Registered Nurse		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence M. Snider				14. MOTHER'S MAIDEN NAME Bessie Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. 212-24-3002		17. INFORMANT Mr. Arthur Stern (Husband)		Address Braddock Heights, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Lower nephron nephrosis 2 days DUE TO (c) Acute fatty liver 1/2 months?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/28, 1958, to 9/20, 1958, that I last saw the deceased alive on 9/20/1958, and that death occurred at 1:50 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. L. Schubert</i> ADDRESS (Street, city or town, state) <i>728 N. Market St. Frederick</i> DATE SIGNED <i>1958</i>							
PHYSICIAN'S NAME (Type) L. R. Schubert		M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Schubert</i>		ADDRESS 1201 N. Market St. Fred		24a. REC'D BY REGISTRAR Md. SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10173

10177

Reg. Dist. No.

1 M 69		1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b>					
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		b. COUNTY			
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Butler</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		3. NAME OF DECEASED (Type or print) <b>Lula</b>		First <b>B</b>	Middle <b>E</b>	4. DATE OF DEATH <b>September 29</b>	Month <b>September</b>	Doy <b>29</b>	Year <b>1958</b>
		5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1905</b>	9. AGE (In years from birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houskeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
		13. FATHER'S NAME <b>Daniel Stone</b>		14. MOTHER'S MAIDEN NAME <b>Martha Diggs</b>		Address <b>Leslie Stone 167 W. All Saint St.</b>			
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>205-12-4688</b>		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-Sclerotic heart disease</b> (c) <b>Cardiac infarce new &amp; old</b> DUE TO (d) <b>Natural causes</b> (e) <b>Undetermined manner</b> (f) <b>Inspection</b> (g) <b>Inquiry</b> (h) <b>Autopsy</b> (i) <b>Death resulted from</b> (j) <b>Accident</b> (k) <b>Suicide</b> (l) <b>Homicide</b> (m) <b>Other</b> (n) <b>None</b> (o) <b>Unknown</b> (p) <b>Other</b> (q) <b>None</b> (r) <b>Unknown</b> (s) <b>Other</b> (t) <b>None</b> (u) <b>Unknown</b> (v) <b>Other</b> (w) <b>None</b> (x) <b>Unknown</b> (y) <b>Other</b> (z) <b>None</b> (aa) <b>Unknown</b> (bb) <b>Other</b> (cc) <b>None</b> (dd) <b>Unknown</b> (ee) <b>Other</b> (ff) <b>None</b> (gg) <b>Unknown</b> (hh) <b>Other</b> (ii) <b>None</b> (jj) <b>Unknown</b> (kk) <b>Other</b> (ll) <b>None</b> (mm) <b>Unknown</b> (nn) <b>Other</b> (oo) <b>None</b> (pp) <b>Unknown</b> (qq) <b>Other</b> (rr) <b>None</b> (ss) 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—MEIGE E AVANTAGE CELESTIALES DE LA TERRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10190 CERTIFICATE OF DEATH

10178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JOHNSVILLE</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JOHNSVILLE</b>	
d. STREET ADDRESS <b>JOHNSVILLE</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT STUARD STULLER</b>		First <b>H</b>	Middle <b>E</b>
		Last <b>R</b>	4. DATE OF DEATH <b>SEPT 3 1958</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 5-1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BY DAY</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>SAMUEL STULLER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH KEMPER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-5165</b>	17. INFORMANT <b>BEULAH STULLER UNION BRIDGE MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO  (c) DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/19. 1958</b> to <b>9/3 1958</b> , that I last saw the deceased alive on <b>9/3 1958</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. E. Robertson</b>	PHYSICIAN'S NAME (Type) <b>M. E. ROBERTSON</b>	ADDRESS (Street, city or town, state) <b>New Windsor, Md.</b> DATE SIGNED <b>9/4/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 9/6/58</b>	22b. DATE THEREOF <b>9/6/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>LUTHERAN CEM. UNIONTOWN, MD</b>	22d. LOCATION (City, town, or county) <b>UNIONTOWN, MD</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>D.D. Hartley &amp; Sons Union Bridge Md.</b>		ADDRESS <b>D.D. Hartley &amp; Sons Union Bridge Md.</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 8 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>A. Stuller &amp; Son</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

67.390M12A8-RTM190 PREMIUM QUALITY STATE OF THE ART

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10191

10179

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>		c. LENGTH OF STAY IN lb <b>20 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Murvil</b>	Middle <b>L.</b>	Last <b>Toms</b>	4. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1910</b>	9. AGE (in years lost birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>road construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Martin Luther Toms</b>		14. MOTHER'S MAIDEN NAME <b>Estie V. Reeder</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <b>214-10-4481</b>		17. INFORMANT Address <b>Mrs. Edna Toms, Middletown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Self inflicted Gun shot wound of head					
INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 26, 1958</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Boonsboro Cemetery</b>	22d. LOCATION (City, town, or county) <b>Boonsboro</b>	(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>
VS. A15ME SM 2/57					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10180

10174

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 South Market Street	d. STREET ADDRESS 126 South Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frank Joseph Tyerryar	First Middle Last	4. DATE OF DEATH Sept. 9 19 58	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12-1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Retail Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick F. Tyerryar		14. MOTHER'S MAIDEN NAME Mary Tuman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-2740 17. INFORMANT Franklin J. Tyerryar-11 W. South St., Frederick-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hypertensive arteriosclerosis, cardio-vascular disease with probable acute myocardial infarct 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-15-1956 to 9-9-1958, that I last saw the deceased alive on 9-9-1958, and that death occurred at 12 Noon, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Rex R. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12-58 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick Maryland		23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son	
24a. REC'D BY REGISTRAR DATE SEP 15 '58		24b. REGISTRAR'S SIGNATURE Albert S. Hause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

好。2007年1月1日-2008年1月1日，新規規範之關係。

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10177

## CERTIFICATE OF DEATH

Reg. Dist. No. 10181

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Brunswick</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>507 East Potomac St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Hannah</b>	Middle <b>Mary</b>	Last <b>Walter</b>	4. DATE OF DEATH	Month <b>9</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX	6. COLOR OR RACE <b>Female</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-29-1875</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchandise</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Robert Walter</b>		14. MOTHER'S MAIDEN NAME <b>Roberta Brannon</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ida L. Willey, Brunswick, Maryland</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5</b> , 19 <b>58</b> , to <b>Sept. 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 17</b> , 19 <b>58</b> , and that death occurred at <b>8:20 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>C. T. Byron Kao</i> PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b>		M.D. <b>15 So. Maryland Ave.</b>		ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b>		DATE SIGNED <b>9-18-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Faste</i>		ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10182

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shookstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		X Shookstown Frederick R.F.D. 7	
e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jerome</b>		First <b>Domnick</b>	Middle <b>Wickless</b>
4. DATE OF DEATH <b>September 21</b>		Month <b>1958</b>	Day <b>Year</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		8. DATE OF BIRTH <b>May 16, 1882</b>	9. AGE (In years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Frederick Co.</b>
13. FATHER'S NAME <b>Anthony Wickless</b>		14. MOTHER'S MAIDEN NAME <b>Laura Joy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Cora Wickless, Frederick R.F.D. 7</b>
No		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary Occlusion	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Partly) <b>Burial</b>		22b. DATE THEREOF <b>9/24/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Catholic Cem.</b>
		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hobart E. Dailey</i>		ADDRESS <b>1201 N. Market st. Frederick</b>	24a. REC'D BY REGISTRAR <b>MD SEP 25 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10193

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

10183

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville-Rural RD#1</b>		c. LENGTH OF STAY IN 1b <b>4 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Knoxville-Rural RD#1</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosemont</b>			d. STREET ADDRESS <b>/ Rosemont</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>MARGARET</b>		First <b>JANE</b>	Middle <b>WILES</b>	Last <b>WILES</b>	4. DATE OF DEATH <b>September 8, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>6 Aug 1870</b>	9. AGE (In years lost birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Year <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Mullican</b>			14. MOTHER'S MAIDEN NAME <b>Victoria Lare</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William C. Wiles (Same as item #1)</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <b>(b)</b> DUE TO <b>(c)</b>			<i>Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Brunswick, Md.</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>Sept 1958</b> , to <b>Sept 1958</b> , that I last saw the deceased alive on <b>Sept 1958</b> , and that death occurred at <b>Brunswick, Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b>								
DATE SIGNED <b>9-8-58</b>								
ACTUAL SIGNATURE <i>[Handwritten Signature]</i>								
PHYSICIAN'S NAME (Type) <b>J. G. F. Smith, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-11-58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS	24a. REC'D BY REGISTRAR DATE <b>SEP 10 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Mann</i>		

## MISSOURI STATE DEPARTMENT OF HEALTH - FATHOMS 18

## CERTIFICATE OF DEATH

DEATH CERTIFICATE NO.	1103
NAME OF DECEASED	JOHN J. MURRAY
SEX	MALE
AGE	60
DATE OF BIRTH	APRIL 10, 1888
PLACE OF BIRTH	ST. LOUIS, MO.
DATE OF DEATH	MARCH 15, 1948
PLACE OF DEATH	HOSPITAL
CAUSE OF DEATH	HEART DISEASE
TIME OF DEATH	10:00 A.M.
TIME OF ISSUANCE	10:00 A.M.
ISSUED TO	DR. R. E. HARRIS
ISSUED BY	CLERK
APPROVED	CLERK